481—73.1(10A) Definitions.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

"Authorized representative" within the context of these rules means that person appointed to carry out audit or investigative procedures, including assigned auditors, investigators, or agents contracted for specific audits or investigative procedures.

"Bureau" means the Medicaid fraud control bureau.

"Claim" means a tangible and legible history which documents the criteria established for clinical records as set forth in rule 441—79.3(249A).

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

"Customary and prevailing" means (1) the most consistent charge by a Medicaid provider for a given service and (2) a fee within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Fiscal agent" means an organization which processes and pays claims on behalf of the department of human services.

"Fiscal record" means a tangible and legible history which documents the criteria established for fiscal records as set forth in human services rule 441—79.3(249A).

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some authorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or state law.

"Generally accepted auditing procedures" means those procedures published in Standards for Audit of Governmental Organizations, Programs, Activities & Functions, 1972 edition, by the Comptroller General of the United States.

"Overpayment" means any payment or portion of a payment made to a provider which is incorrect according to the laws and rules applicable to the Medicaid program and which results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier which describes medical services performed or the supplies, drugs or equipment provided.

"Provider" means an individual, firm, corporation, association, or institution which provides or has been approved to provide goods or services to someone receiving state medical assistance.

"Random sample" means a systematic (or every nth unit) sample for which each item in the universe has an equal probability of being selected.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items (claims), submitted by a specific provider for payment during a specific time period, from which a random sample will be drawn.